TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
HERMANN HOSPITAL

Respondent Name
AMERICAN HOME ASSURANCE COMPANY

MFDR Tracking Number
M4-98-9907-02

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 21, 1998

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 1996 to June 3, 1997	Hospital Services	$2,779.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a benefit review conference.
3. Texas Labor Code Chapter 410 Subchapter B. sets out procedures regarding benefit review conferences.
4. The insurance carrier denied payment for the disputed services in whole or in part with the following payment exception codes:
   - E – Entitlement (non-compensable)
   - R – Charge Unrelated to Compensable Injury
5. Additionally, the respondent presented a copy of a form TWCC-21 notice disputing liability for the injured employee's injury.

Issues

1. Are there unresolved issues of compensability, extent of injury, or liability regarding the services in dispute?
2. Can the Division adjudicate the medical fee issues in this dispute?

Findings

1. Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury, or liability for the same service(s) for which there is a medical fee dispute. No documentation was presented to support that the issue(s) of compensability, extent or liability have been resolved.

   The appropriate dispute process for unresolved issues of compensability, extent of injury, or liability regarding disputed services requires the health care provider to submit a request for a benefit review conference

pursuant to 28 Texas Administrative Code §141.1. All outstanding issues regarding compensability, extent of injury, or liability for the disputed services must be resolved before requesting medical fee dispute resolution.

2. The requestor has failed to support that the outstanding issues regarding compensability, extent of injury or liability for the disputed services have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 before submitting a request for medical fee dispute resolution regarding the same services. Consequently, the Division cannot review the medical fee issues in dispute.

Conclusion

For the reasons stated above, the Medical Fee Dispute Resolution section cannot review the disputed services. As a result, no additional payment can be ordered. The merits of the medical fee issues have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 18, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.